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AUTHOR Metzger, David S.; Platt, Jerome J.
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ABSTRACT

The growing number of treatment programs for people who drink and drive requires that these programs be clearly understood. The judicial mandate for treatment creates not only a significant opportunity to modify behavior and improve personal and interpersonal functioning, but also brings with it an obligation to implement programs which reflect sound clinical practices. Yet little investigative attention has been devoted to these programs, the clients they serve, and the programs' impact. An 18-month study of the counseling component of the Philadelphia Alcohol Highway Safety Program assessed clients at intake to treatment, monitored their participation during treatment, and assessed them again at termination of treatment. The 369 clients involved in the study represented a broad range of ages, income levels, living situations, driving histories, and employment characteristics. Counselor ratings of clients' reasons for termination and their goal attainment were examined in an attempt to identify relationships between client characteristics and global outcome status. The results of analyses of variance identified six variables having significant relationships with positive treatment outcomes: age, marital status, drinking quantity, drinking frequency, valid driver's licenses and insurance coverage, and drinking-driving histories. Clients who terminated treatment in non-compliance accounted for 20 percent of all terminations. (NRB)

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PROBLEM DRINKER DRIVERS: CLIENT CHARACTERISTICS, SERVICE INVOLVEMENT AND TREATMENT OUTCOME

David S. Metzger, M.S. and Jerome J. Platt, Ph.D.
Hahnemann University
Department of Mental Health Sciences
Broad & Vine
Philadelphia, PA 19102

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Introduction

The recent wave of anti drinking driving legislation in the United States has brought with it a large scale effort to move those arrested into programs of treatment. Although the response systems which have been established vary in their structure and process from state to state, several global features are common. These include enforcement contingent punitive sanctions such as license suspension, fines, incarceration, and community service hours as well as rehabilitative efforts involving some form of mandated educational and counseling program involvement. In many areas, such programscurrently account for more referrals to alcohol treatment services than any other single source.

Yet, to date, relatively little investigative attention has been devoted to these programs, who they serve, and their impact. These services have been legislated into existence based not upon their known efficacy, but rather based upon a belief in the paradigm of treatment. The purpose of this paper is to suggest that before we establish an orthodoxy of practice, we should maintain an experimental mentality which is dedicated to the development and implementation of the most effective interventions.

The data reported here eminate from an 18 month study of the counseling component of the Philadelphia Alcohol Highway Safety Program. The study was funded by the Pennsylvania Department of Transportation in conjunction with the City of Philadelphia Coordinating Office of Drug and Alcohol Abuse Programs.

The Philadelphia Alcohol Highway Safety System has been in

existence for over ten years. Drinking drivers are identified by the police and tested centrally. If the drivers' breath tested Blood Alcohol Content (BAC) is .10% or higher, he (or in 5% of the cases , she) is charged with driving under the influence, and a court date is set for the initial hearing -- usually within two weeks. A pretrial investigation of the clients' past driving record and criminal history are prepared and reviewed in the interim in order to determine eligibility for diversion in lieu of trial. If eligible, the offender is given the option of entering a guilty plea or challenging the charge and proceeding with a trial. Individuals who plead guilty are given an appointment for a structured interview conducted by the National Council on Alcoholism. If judged to be a problem drinker as a result of this assessment, the individual is then required to participate in a series of safe driving classes followed by at least 15 weeks of outpatient alcohol counseling.

The evaluation assessed clients at intake to treatment, monitored their participation during treatment, and assessed clients again at termination from treatment. Reported here are findings from two major areas of our study: (1)the characteristics of the clients entering treatment, and (2)the relationship between these characteristics and global outcome status. Before reporting these findings, however, it would appear that an important consideration in understanding the drinking driver problem is the environment in which such behavior takes place.

Who are the Clients?

The 369 clients who together comprised the study group were diverse in many ways. They represented a broad range of ages, income levels, living situations, driving histories, and employment characteristics. At the same time, there were similarities among this group which stand in striking contrast to their diversity. They were almost exclusively male; with few exceptions they denied any problems with alcohol; they presented many indicators of social disruption, and, above all, they were all apprehended for driving under the influence of alcohol. They had an average age of 42 years, ranging from a low of 19 to a high of 80. The majority of subjects (54.5%) were over the age of forty and 30.1% were older than fifty. These figures highlight not only the broad mixture of ages and, consequently, lifestyles, represented among clients involved together in treatment but also the long term nature of drinking habits of the majority of clients.

Of the study group, 351 (95.1%) were male and 18 (4.9%) were female. In spite of the strikingly small percentage of women involved, these figures generally concur with DUI arrest statistics and alcohol involved accident data. Forty-six percent had completed high school. Among the study group, only 39% were currently married and living with their spouse, 26.5% had never married, 11.7% were divorced, 18.7% were currently separated, and 3.8% were widowed. In light of the age characteristics of the population mentioned above, these figures emphasize an unusually high degree of family and social disruption. This is also reflected in the fact that just over half of the study group

(52.2%) were employed at the time of their entry into counseling, while 40.1% were unemployed. Their average gross weekly income amounted to $228.00, ranging from a high of $800.00 to a low of $33.00. Forty-seven clients reported no income at all. For those clients with available data (258) the average blood alcohol content (BAC) was .19% at the time of their arrest, the approximate equivalent of 10 drinks by a 160 pound individual within one hour's time. There is probably no more powerful single by this group. While the mean reading was .19, over 56% had BACs above .20 and over 14% were over .25. The significance of these figures regarding the impairment of functioning is clear. Such impairment has been demonstrated to begin at a BAC of .05%. For drivers with BACs of .10% the relative probability of fatal crash involvement is 12 times higher than that of the non-drinking driver. At .15% BAC, the relative probability of accident involvement is more than 20 to 1.

The arrest records of these clients provide further evidence of the severity of problem drinking. Overall, 60.5% had prior arrest records. These arrests were not traffic violations but involved criminal and civil charges. Of these 51% were alcohol related. Thus, nearly one-third (30.9%) of all subjects had a prior, non-traffic, alcohol related arrest.

The driving records of these clients as reported by the Department of Transportation and program staff revealed that subjects had, as a group, accumulated a total of 47 prior DUI charges, 49 charges of reckless driving, 6 hazardous moving violations, and 52 administrative actions (license revocation,

suspension, etc.). These figures, however, must be cautiously viewed as conversative in light of several factors. First, 16% of all subjects had no license or information on file. Thus, any past violations of these clients would not be included in the above figures. Secondly, the data base which is searched by the Department of Transportation is not completely accurate as some arrests may not be on file nor would arrests in other states be routinely included.

As stated, 16% had no license. In addition, however, 22.2% were, at the time of their arrest, driving while their license was suspended or revoked. Only 61.1% had valid driver's licenses, and only 78.4% had insurance coverage. The extent of problem drinking among this group is also indicated by the fact that 14.5% of the subjects had been involved in prior alcohol treatment programs.

This data then summarize the characteristics of the clients as they entered their treatment programs. Clearly, they, as a group, represent a population of problem drinkers and many would certainly meet or exceed criteria for a diagnosis of alcoholism.

Treatment Impact and Outcome

In relation to impact it is important to begin by stating that the great majority of clients do complete their counseling program, most of whom achieved at least some of their treatment goals. Using the strictest criteria of success, 40% of the clients were terminated and judged to be in need of no further services, and 18% of all clients terminated were assessed as having achieved all of their treatment goals. Undoubtedly, for many of those clients, their counseling experience had impact.

Of those terminated in non-compliance, we can say little other than the fact that they accounted for just over 20% of all terminations among these subjects -- in spite of the court order to participate.

Two global measures were used in an attempt to identify relationships between client characteristics and global outcome status: these were (1)reason for termination and (2)goal attainment. Both were based upon counselor ratings at the point of discharge from treatment.

Correlational analyses identifiedseven variables significantly related to our dependent measures. These correlations suggest that more positive outcome status was associated with clients who were older ($p < .05$), more liklely to be currently married ($p < .05$), to have provided information which yielded lower scores on quantity and frequency of drinking measures ($p < .05$), more likely to have a valid license at the time of arrest ($p < .05$), more likely to have insurance coverage ($p < .05$) and less likely to have a prior alcohol related driving offense ($p < .05$).

Analyses of variance were computed in an attempt to further test the strength of these relationships. The results of these analyses identified six variables having significant relationships with our dependent measures. These were <u>age</u>: older clients had more positive outcomes ($p < .05$); <u>marital status</u>: those currently married and living with their spouse had more positive termination status ($p < .05$); <u>drinking quantity</u> and <u>frequency indices</u>: those with lower score achieved better

outcome ($p < .01$), as did those with valid licenses insurance coverage ($p < .05$) and better driving histories ($p < .05$).

In essence, those who entered treatment with more positive indications of social functioning performed better in treatment - a common finding in evaluation research. One additional finding is worthy of note. Two subjects died while in treatment. The similarities of these two cases were striking and stand in sharp contrast to their diversity from the other subjects followed in this study. Both were males under 25 years of age and unemployed. Both had reported drug abuse in addition to their excessive use of alcohol. Both were white and unmarried. In one case the cause of death was suicide, in the other death resulted from a drug overdose with a suspician of suicide.

CONCLUSIONS

The multiplicity of familial, economic, social and legal problems of problem drinker drivers is clearly delineated in the data presented. The question of whether or not these problems are the result or the cause of problem drinking highlights a longstanding debate among treatment professionals. It is a question that this paper does not attempt to answer. Regardless of the precise nature of the causal relationships which exist, however, the growing number of such programs in the United States requires that their role and expectations be clearly understood. The judicial mandate for treatment creates not only a significant opportunity to modify behavior and improve personal and interpersonal functioning, but also brings with it an obligation to implement programs which reflect sound clinical practice. To date there has been little research devoted to the issues of

treatment which go beyond global assessments of impact. As is true in other areas of substance abuse treatment research, we must focus investigative energies more precisely upon which clinical approaches are best for which types of individuals and under what circumstances. The widespread practice of assigning drinking drivers to treatment is a positive judicial response reflecting a belief in the behavior changing potential of clinical interventions. It is not, however, a panacea and demands substantially more professional scrutiny than has been historically devoted to it. It may turn out that it will be a sizeable struggle to maintain a clinical focus to such programs in light of the legislative mandates which structure their functioning.